

Idaho Industrial Commission
Rehabilitation Division
REFERRAL FORM

Internal Use Only

IC Claim # _____
Rehab # _____
Consultant _____
Office _____
Date faxed to Boise _____
☐ New ☐ Reopened

To make a referral, complete this form (to the best of your knowledge) and send it to either the local Industrial Commission Rehabilitation office *or* the main office in Boise.

Please provide medical information and accident report with this referral form.

(Please Print)

Claimant:

Name: _____
Social Security No. _____ Birthdate _____
Address (Home) _____
(Mailing) _____
Phone No. (Home) _____ Phone No. (Message) _____
Date of Injury _____ Type of Injury _____
Is Claimant Working? ☐ Yes ☐ No Claimant Occupation _____

Employer:

Name _____ Contact _____
Address _____ Phone No. _____

Surety:

Name _____ Case No. _____

Adjuster:

Name _____ Phone No. _____

Treating Physician: _____

Attorney:

Name _____ Phone No. _____

Has claimant been notified of this referral? Yes ☐ No ☐

Referral Source Information:

Name (Referred by) _____
Of (company name) _____ Date of referral _____
Source type: ☐ attorney ☐ employer ☐ medical provider ☐ self-referral
☐ surety ☐ other _____

Reason for Referral/Comments:

